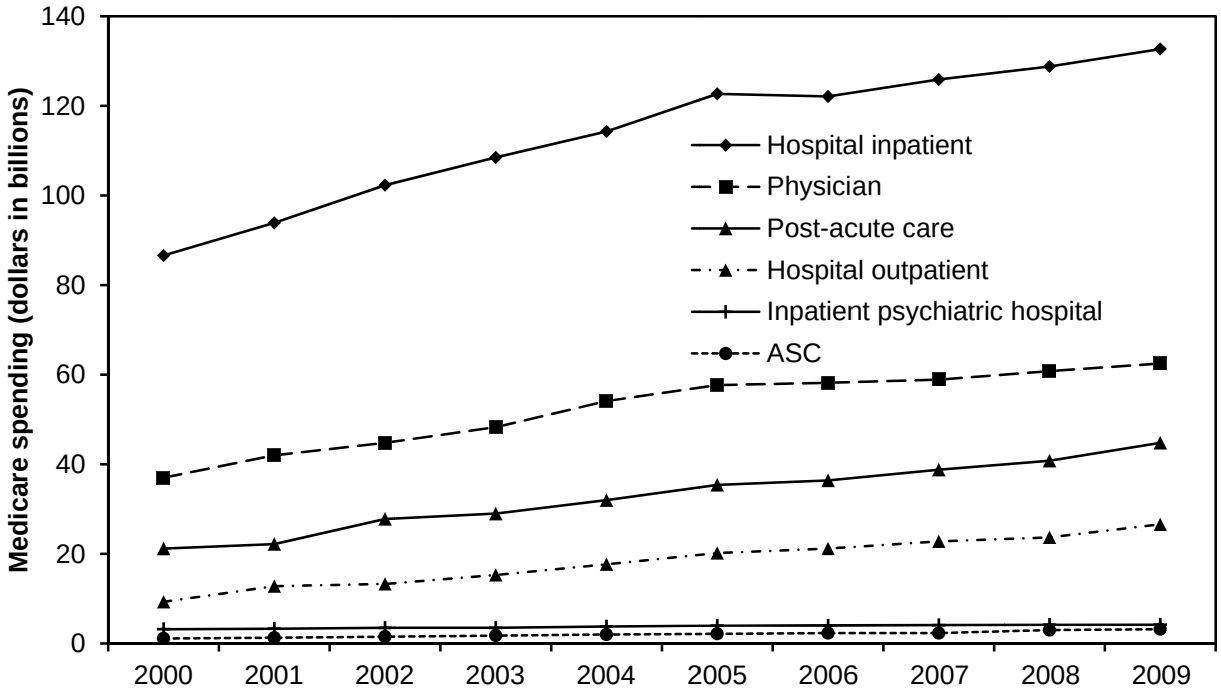
SECTION 1

National health care and Medicare spending

Chart 1-1. Aggregate Medicare spending among FFS beneficiaries, by sector, 2000–2009

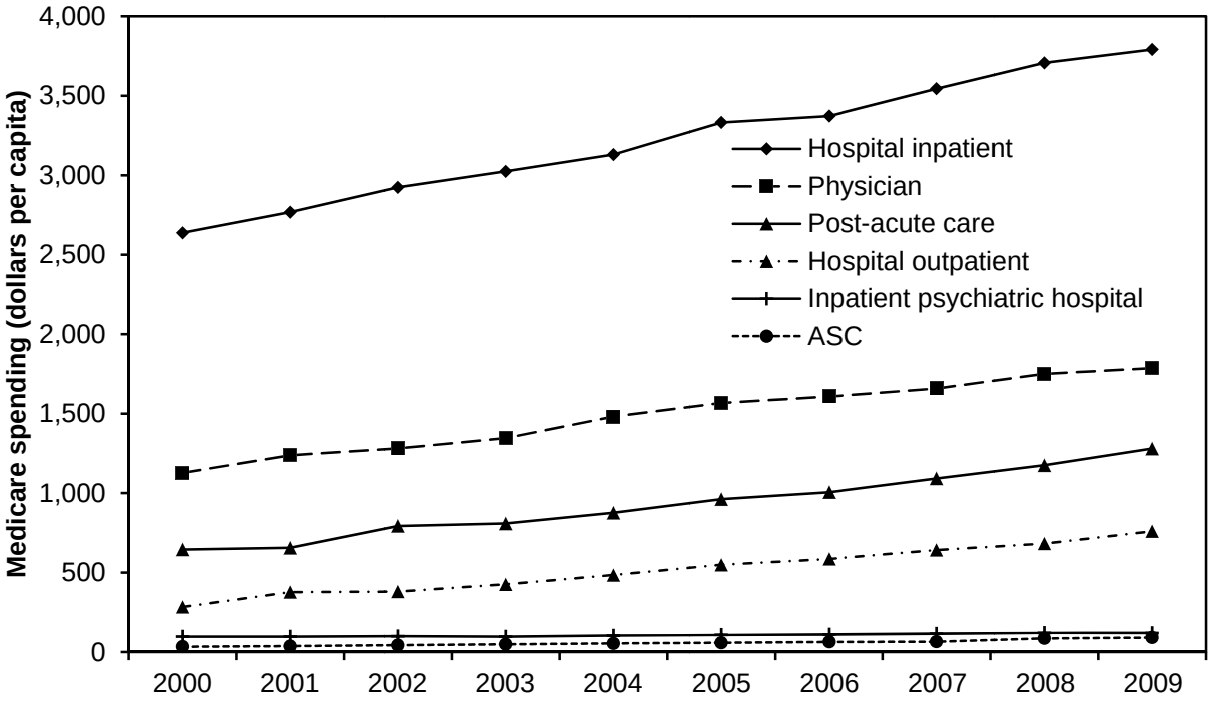


Note: FFS (fee-for-service), ASC (ambulatory surgical center). Dollars are Medicare spending only and do not include beneficiary cost sharing. The growth in spending slowed between 2006 and 2008 due to large increases in the number of Medicare Advantage enrollees, whose spending is not included in these aggregate totals.

Source: CMS, Office of the Actuary and the 2011 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Medicare spending among fee-for-service (FFS) beneficiaries grew strongly in most sectors from 2000 through 2004. Spending growth slowed slightly from 2005 to 2007 but rebounded in some sectors from 2008 to 2009. The slowing in aggregate spending from 2005 to 2007 is partially attributable to a decline in the number of FFS beneficiaries.

Chart 1-2. Per capita Medicare spending among FFS beneficiaries, by sector, 2000–2009

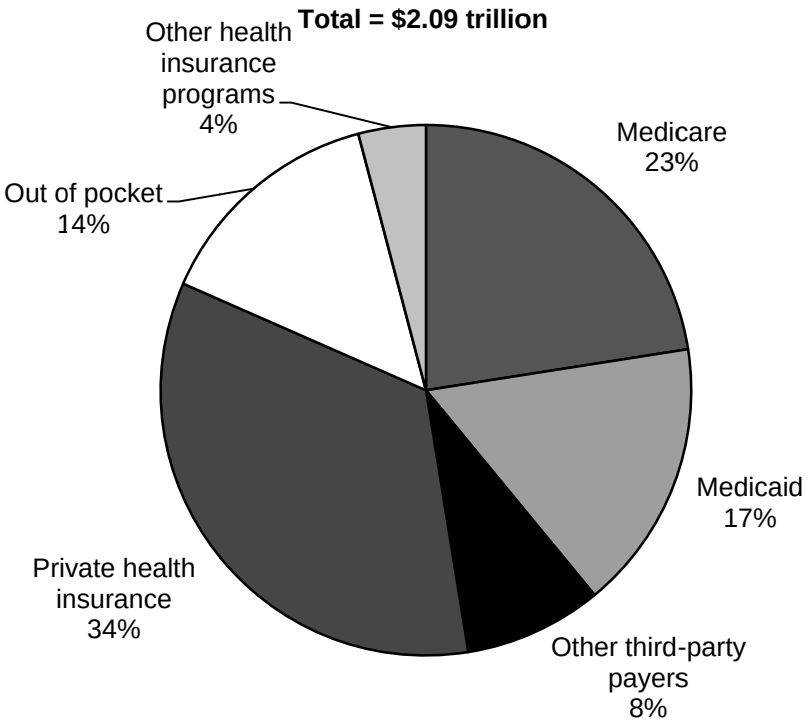


Note: FFS (fee-for-service), ASC (ambulatory surgical center). Dollars are Medicare spending only and do not include beneficiary cost sharing.

Source: CMS, Office of the Actuary and the 2011 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Medicare spending per beneficiary in fee-for-service Medicare increased steadily in most sectors from 2000 through 2009, with some sectors growing faster from 2006 to 2009.

Chart 1-3. Medicare made up over one-fifth of spending on personal health care in 2009



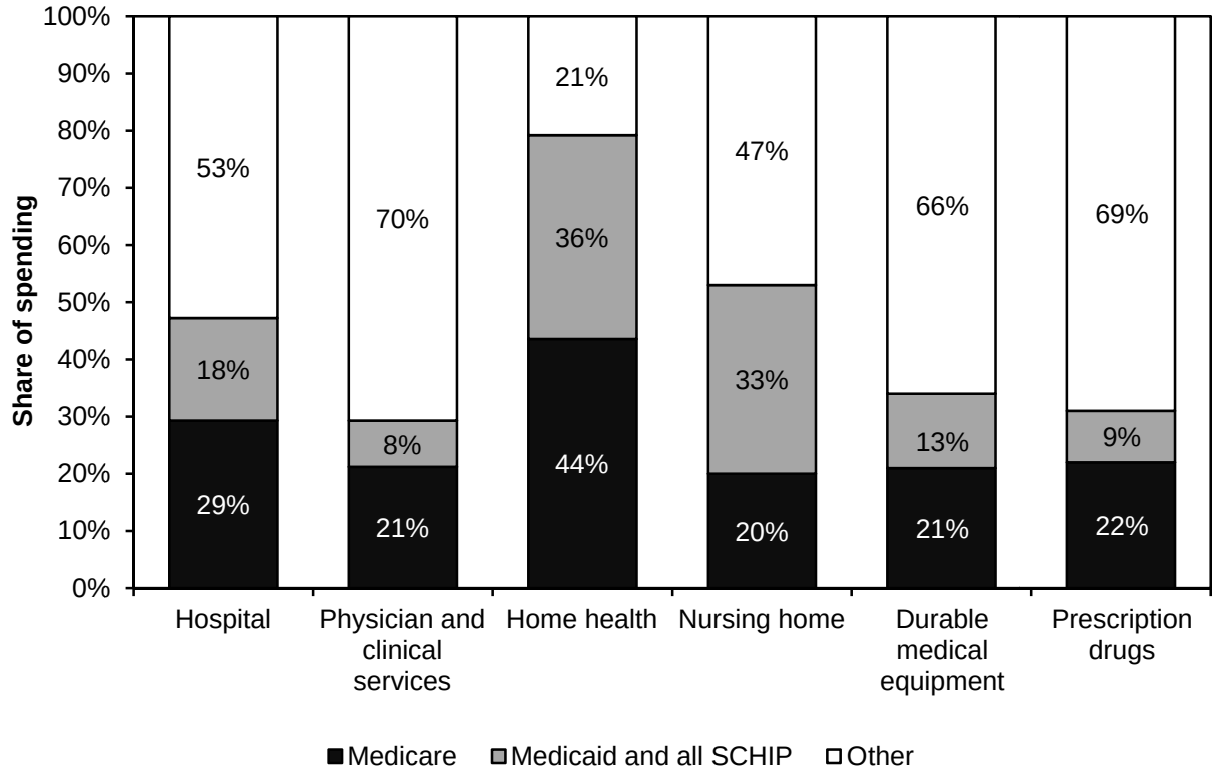
Note: Out-of-pocket spending includes cost sharing for both privately and publicly insured individuals. Personal health care spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits. Premiums are included with each program (e.g., Medicare, private insurance) rather than in the out-of-pocket category. Other health insurance programs include the Children's Health Insurance Program, Department of Defense, and Department of Veterans' Affairs. Other third-party payers include worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2011.

- Of the $2.09 trillion spent on personal health care in the United States in 2009, Medicare accounted for 23 percent, or $502 billion (as noted above, this amount includes direct patient care spending and excludes certain administrative and business costs). Medicare is the largest single purchaser of health care in the United States. Thirty-four percent of spending was financed through private health insurance payers and 14 percent was from consumer out-of-pocket spending.

- Medicare and private health insurance spending include premium contributions from enrollees.

Chart 1-4. Medicare's share of total spending varies by type of service, 2009

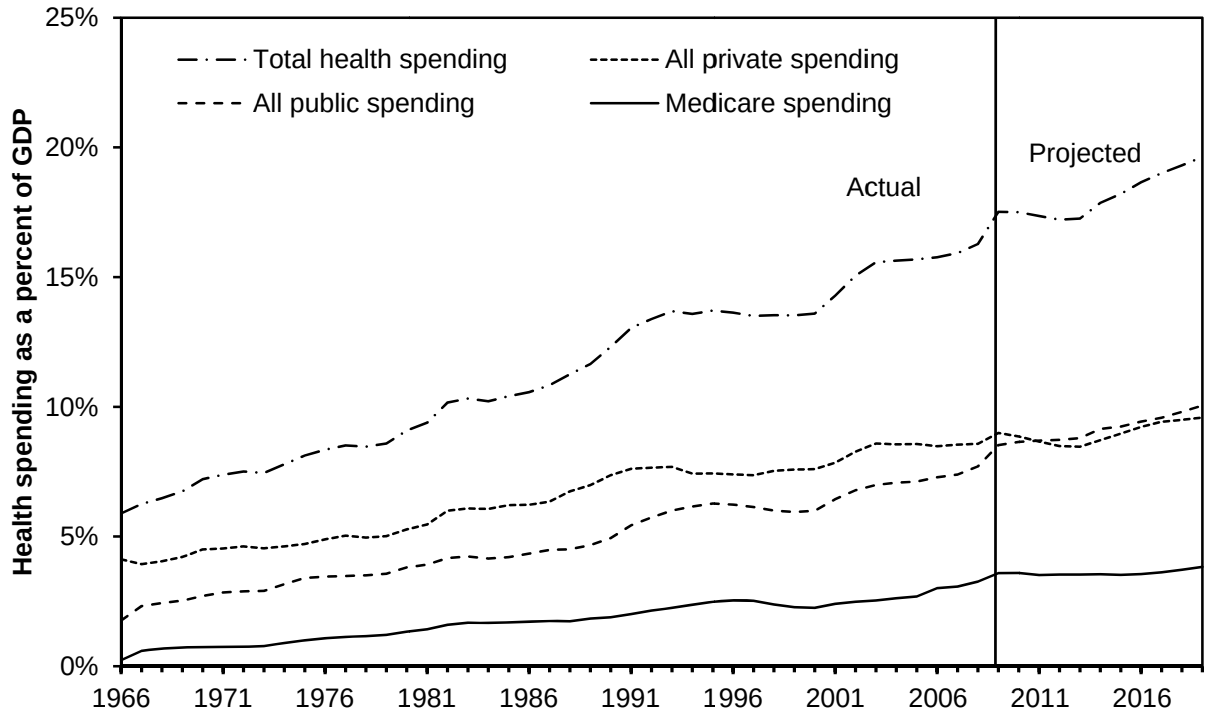


Note: SCHIP (State Children's Health Insurance Program). Personal health spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits. Totals may not sum to 100 percent due to rounding. "Other" includes private health insurance, out-of-pocket spending, and other private and public spending.

Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2011.

- The level and distribution of spending differ between Medicare and other payers, largely because Medicare covers an older, sicker population and does not cover services such as long-term care.
- In 2009, Medicare accounted for 29 percent of spending on hospital care, 21 percent of physician and clinical services, 44 percent of home health services, 20 percent of nursing home care, 21 percent of durable medical equipment, and 22 percent of prescription drugs.

Chart 1-5. Health care spending has grown more rapidly than GDP, with public financing making up nearly half of all funding

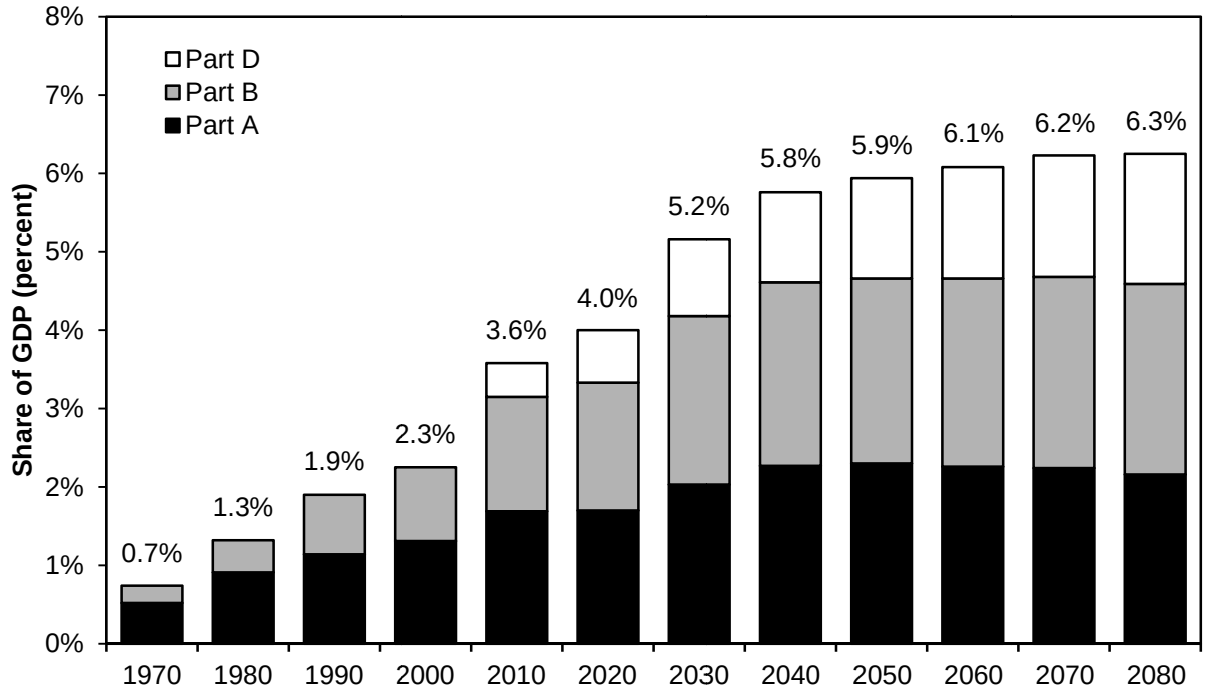


Note: GDP (gross domestic product). Total health spending is the sum of all private and public spending. Medicare spending is one component of all public spending.

Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2011.

- Total health spending consumes an increasing proportion of national resources, accounting for a double-digit share of gross domestic product (GDP) annually since 1982.
- As a share of GDP, total health spending has increased from about 6 percent in 1965 to about 18 percent in 2009. It is projected to reach 20 percent of GDP in 2019. Health spending's share of GDP was stable throughout much of the 1990s due to slower spending growth associated with greater use of managed care techniques and higher enrollment in managed plans as well as a strong economy.
- Medicare spending has also grown as a share of the economy from less than 1 percent when it was started in 1965 to about 3.6 percent today. Projections suggest that Medicare spending will make up 4 percent of GDP by 2019.
- In 2009, all public spending made up about 49 percent of total health care spending and private spending made up 51 percent. By 2019, those percentages are projected to be 51 percent and 49 percent, respectively.

Chart 1-6. Trustees project Medicare spending to increase as a share of GDP



Note: GDP (gross domestic product). These projections are based on the trustees' intermediate set of assumptions.

Source: 2011 annual report of the Boards of Trustees of the Medicare Trust Funds.

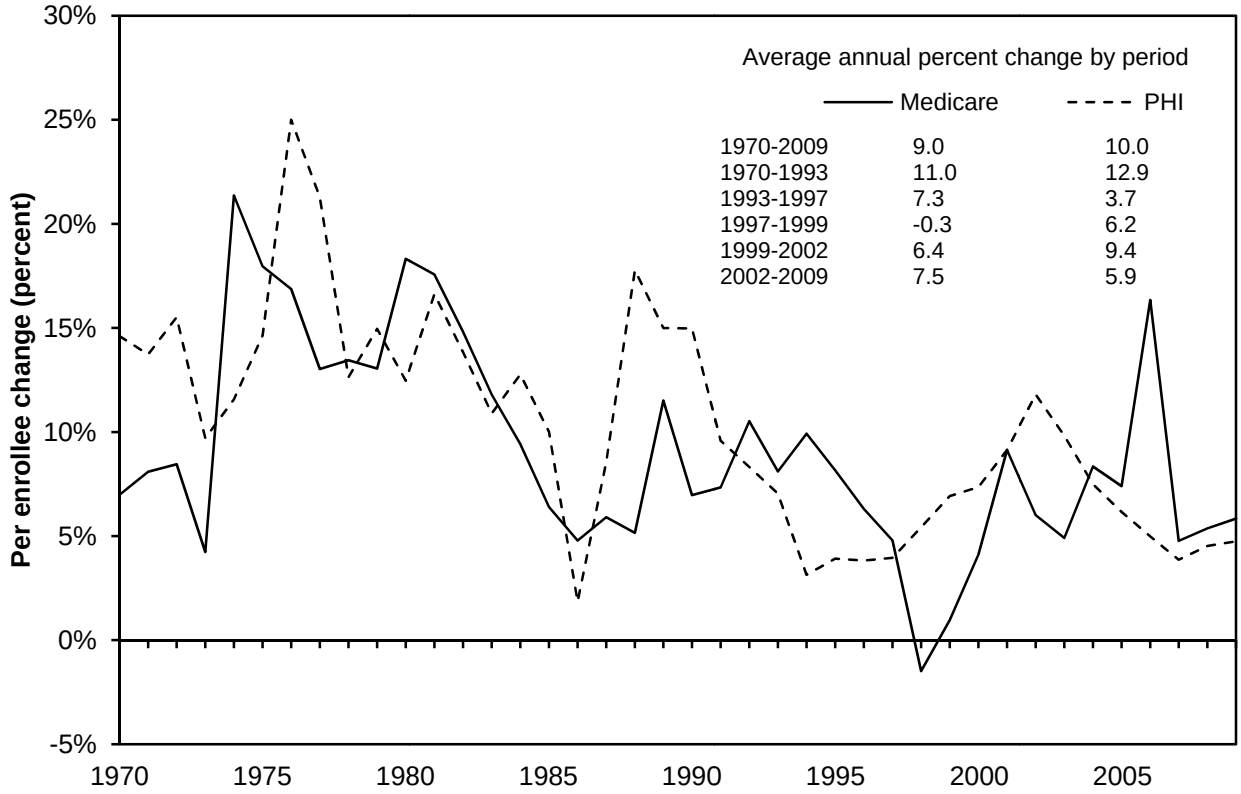
- Over time, Medicare spending has accounted for an increasing share of gross domestic product (GDP). From less than 1 percent in 1970, it is projected to reach over 6 percent of GDP in 2080.

- Nominal Medicare spending grew on average 9.2 percent per year over the period from 1980 to 2010, considerably faster than nominal growth in the economy, which averaged 5.7 percent per year over the same time frame. Future Medicare spending is projected to continue growing faster than GDP, averaging 5.5 percent per year between 2010 and 2080 compared with an annual average growth rate of 4.6 percent for the economy as a whole. In other words, Medicare spending is projected to continue rising as a share of GDP but at a slower pace.

- Medicare's share of GDP is projected to reach 6.3 percent in 2080. This amount is significantly smaller than the projection of Medicare's share of GDP before enactment of the Patient Protection and Affordable Care Act of 2010 (PPACA). Under prior law, in 2009 the Trustees estimated that Medicare's share of GDP would reach 11.2 percent by 2080. This difference is largely due to the permanent productivity adjustments for most providers enacted in PPACA.

- Beginning in 2010, the aging of the baby-boom generation, an expected increase in life expectancy, and the Medicare drug benefit are likely to increase the proportion of economic resources devoted to Medicare, growing from 3.6 percent of GDP in 2010 to 5.8 percent of GDP by 2040. Additional factors such as innovation in medical technology and the widespread use of insurance (which shields individuals from facing the full price of services) will also contribute to increases in health care spending.

Chart 1-7. Changes in spending per enrollee, Medicare and private health insurance



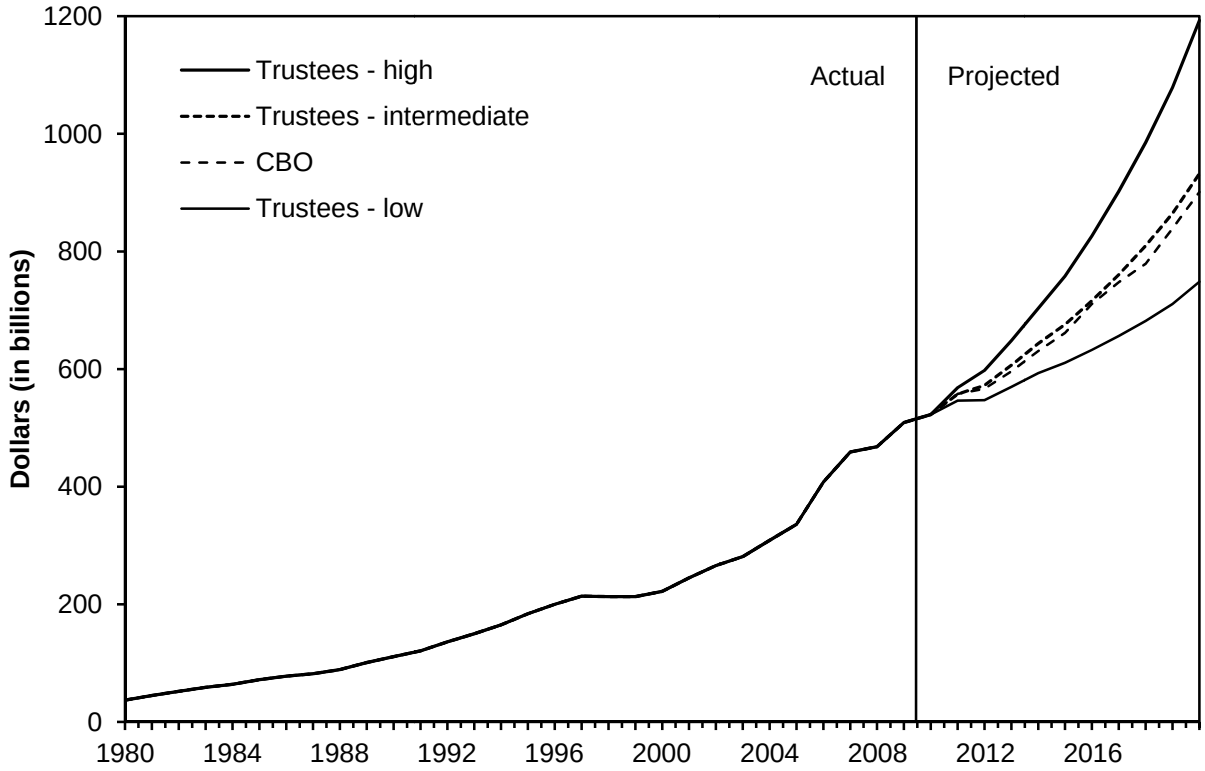
Note: PHI (private health insurance). In most years in this period Medicare and PHI do not cover the same services. Medicare expenditures include both fee-for-service and private plans.

Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2011.

- Although rates of growth in per capita spending for Medicare and private insurance often differ from year to year, over the long term they have been quite similar. However, this comparison is sensitive to the end points of time one uses for calculating average growth rates. Also, private insurers and Medicare do not buy the same mix of services, and Medicare covers an older population that tends to be more costly. In addition, the data do not allow analysis of the extent to which these spending trends were affected by changes in the generosity of covered benefits and, in turn, changes in enrollees' out-of-pocket spending.

- Differences appear to be more pronounced since 1985, when Medicare began introducing the prospective payment system for hospital inpatient services. Some analysts believe that, since the mid-1980s, Medicare has had greater success at containing cost growth than private payers by using its larger purchasing power. Others maintain that, since the 1970s, benefits offered by private insurers have expanded and cost-sharing requirements declined. These factors make the comparison problematic, as Medicare's benefits changed little over the same period.

Chart 1-8. Trustees and CBO project Medicare spending to grow at an annual average rate of between 5.5 percent and 6 percent over the next 10 years

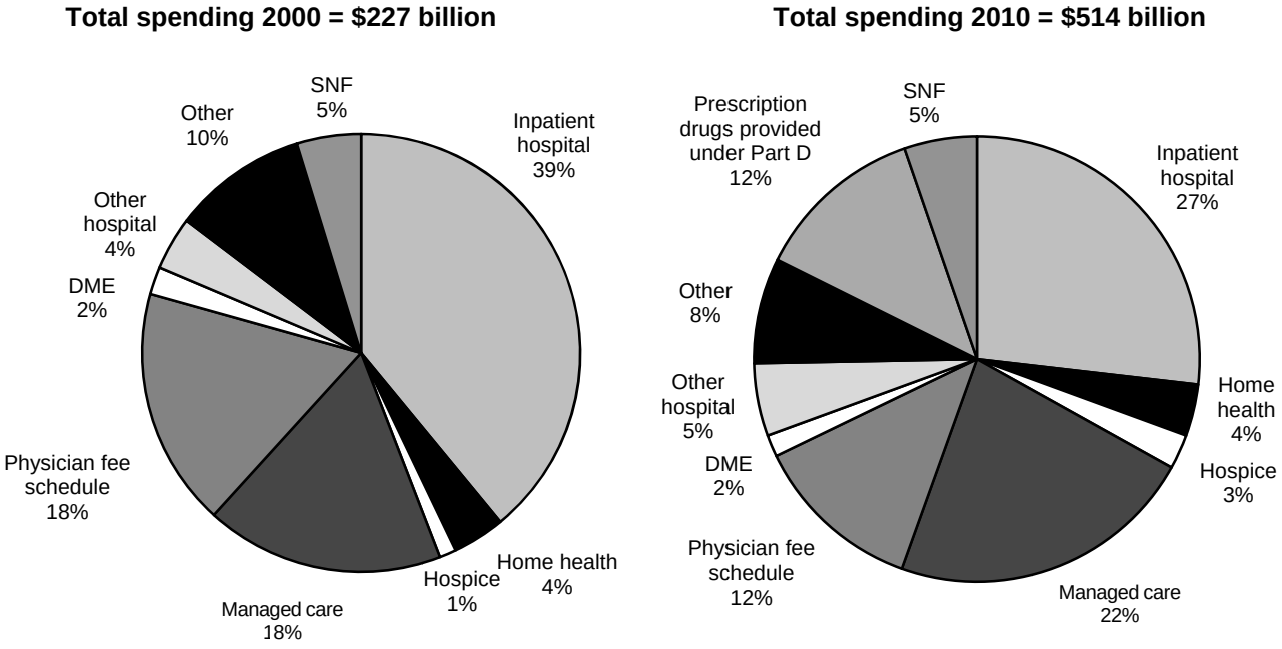


Note: CBO (Congressional Budget Office). All data are nominal, gross program outlays (mandatory plus administrative expenses) by calendar year.

Source: 2011 annual report of the Boards of Trustees of the Medicare Trust Funds. CBO March 2011 baseline.

- Medicare spending has grown nearly 13-fold, from $37 billion in 1980 to $509 billion in 2009 (see Chart 1-3; these data include benefit payments and administrative expenses).
- Medicare spending increased significantly after 2006 with the introduction of Part D, Medicare's voluntary outpatient prescription drug benefit.
- The Congressional Budget Office projects that mandatory spending for Medicare will grow at an average annual rate of 5.5 percent between 2011 and 2020. The Medicare trustees' intermediate projections for 2011 to 2020 assume 5.9 percent average annual growth. Forecasts of future Medicare spending are inherently uncertain, and differences can stem from different assumptions about the economy (which affect provider payment annual updates) and about growth in the volume and intensity of services delivered to Medicare beneficiaries, among other factors.

Chart 1-9. Medicare spending is concentrated in certain services and has shifted over time

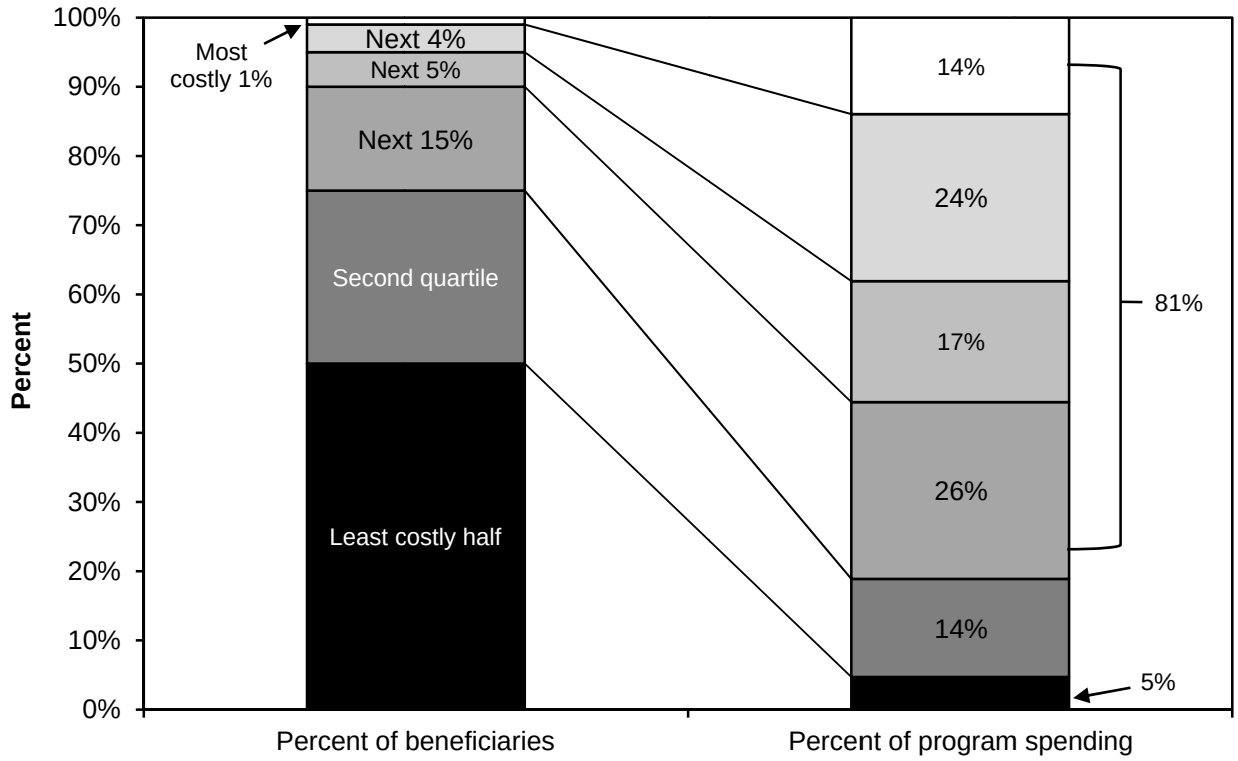


Note: SNF (skilled nursing facility), DME (durable medical equipment). Medicare's outpatient drug benefit began in 2006, and thus the distribution of spending for 2009 differs significantly from earlier years. Spending amounts are gross outlays, meaning that they include spending financed by beneficiary premiums but do not include spending by beneficiaries (or spending on their behalf) for cost-sharing requirements of Medicare-covered services. Values are reported on a fiscal year, incurred basis and do not include spending on program administration. "Other" includes carrier lab, other carrier, intermediary lab, and other intermediary. Totals may not sum to 100 percent due to rounding.

Source: 2012 President's Budget; CMS, Office of the Actuary, 2011.

- The distribution of Medicare spending among services has changed substantially over time.
- In 2010, Medicare spent about $514 billion for benefit expenses. Inpatient hospital services were by far the largest spending category (27 percent), followed by managed care (22 percent), services reimbursed under the physician fee schedule (12 percent), outpatient prescription drugs provided under Part D (12 percent), and other fee-for-service settings (8 percent).
- Although inpatient hospital services still made up the largest spending category, spending for those services was a smaller share of total Medicare spending in 2010 than it was in 2000, falling from 39 percent to 27 percent. Spending on beneficiaries enrolled in managed care plans has grown from 18 percent to 22 percent over the same period. Current Medicare managed care enrollment is higher than it was a decade ago.

Chart 1-10. FFS program spending is highly concentrated in a small group of beneficiaries, 2007



Note: FFS (fee-for-service). Excludes beneficiaries with any group health enrollment during the year. Spending data reflect revised 2007 Medicare Current Beneficiary Survey Cost and Use file from CMS.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use files.

- Medicare fee-for-service (FFS) spending is concentrated among a small number of beneficiaries. In 2007, the costliest 5 percent of beneficiaries accounted for 38 percent of annual Medicare FFS spending and the costliest quartile accounted for 81 percent. By contrast, the least costly half of beneficiaries accounted for only 5 percent of FFS spending.

- Costly beneficiaries tend to include those who have multiple chronic conditions, those using inpatient hospital services, those who are dually eligible for Medicare and Medicaid, and those who are in the last year of life.

Chart 1-11. Medicare HI trust fund is projected to be insolvent in 2024 under actuaries' intermediate assumptions

Estimate	Year costs exceed income	Year HI trust fund assets exhausted
High	2008	2016
Intermediate	2008	2024
Low	2008	Never*

Note: HI (Hospital Insurance). Income includes taxes (payroll and Social Security benefits taxes, railroad retirement tax transfer), income from the fraud and abuse program, and interest from trust fund assets.
* Under the low-cost assumption, trust fund assets would start to increase in 2014 and continue to increase throughout the projection period.

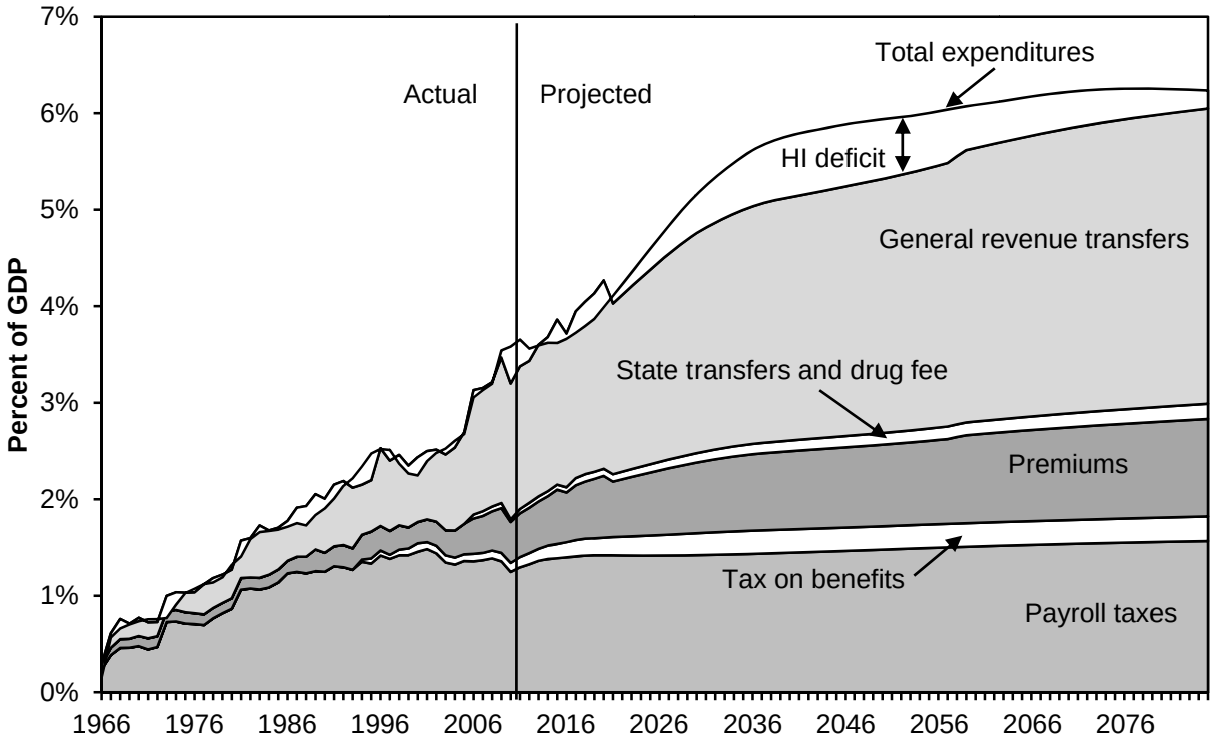
Source: 2011 annual report of the Boards of Trustees of the Medicare Trust Funds; CMS, Office of the Actuary.

- The Medicare program is financed through two trust funds: one for Hospital Insurance (HI), which covers services provided by hospitals and other providers such as skilled nursing facilities, and one for Supplementary Medical Insurance (SMI) services, such as physician visits and Medicare's new prescription drug benefit. Dedicated payroll taxes on current workers largely finance HI spending and are held in the HI trust fund. The HI trust fund can be exhausted if spending exceeds payroll tax revenues and fund reserves. General revenues finance roughly 75 percent of SMI services, and beneficiary premiums finance about 25 percent. (General revenues are federal tax dollars that are not dedicated to a particular use but are made up of income and other taxes on individuals and corporations.)

- The SMI trust fund is financed with general revenues and beneficiary premiums. Some analysts believe that the levels of premiums and general revenues required to finance projected spending for SMI services would impose a significant burden on Medicare beneficiaries and on growth in the U.S. economy.

- HI's expenses exceeded its income in 2008. In 2011, Medicare trustees report that under the intermediate assumptions the HI trust fund will be exhausted in 2024. Under high-cost assumptions, the HI trust fund could be exhausted as early as 2016. Under low-cost assumptions, it would remain able to pay full benefits indefinitely.

Chart 1-12. Medicare faces serious challenges with long-term financing



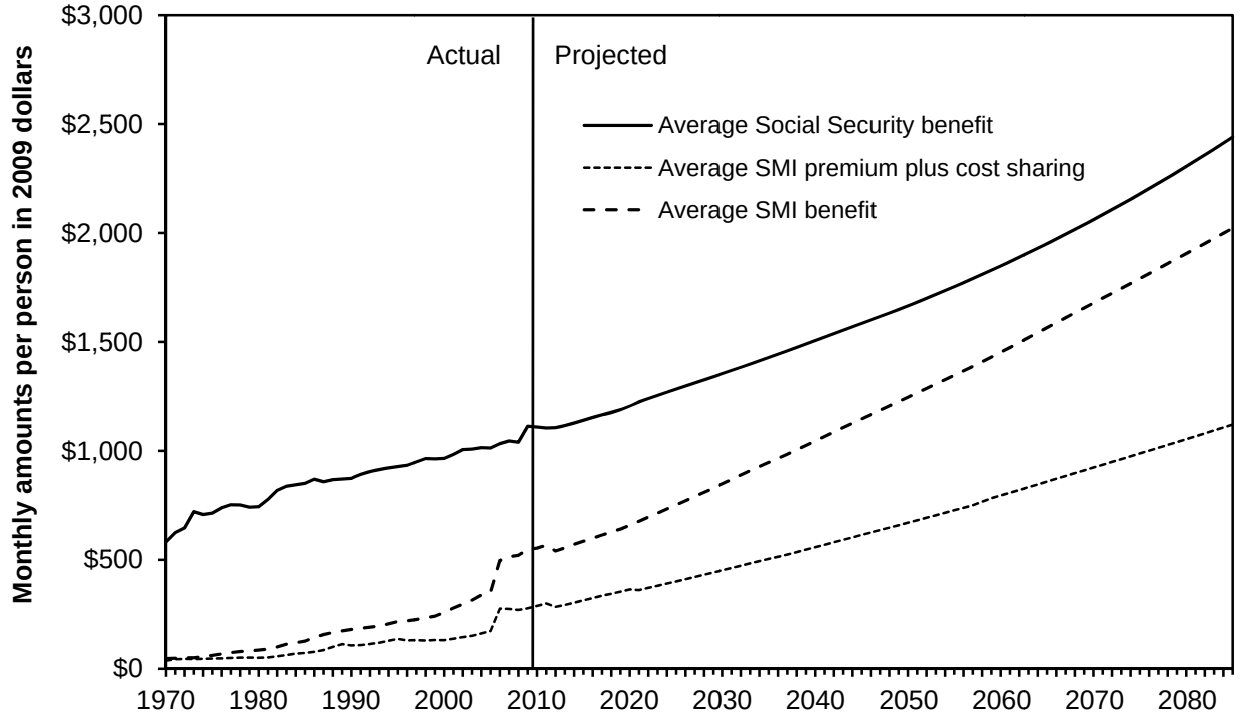
Note: GDP (gross domestic product), HI (Hospital Insurance). These projections are based on the trustees' intermediate set of assumptions. Tax on benefits refers to a portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. State transfers (often called the Part D "clawback") refer to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending. The drug fee refers to the fee imposed in the Patient Protection and Affordable Care Act of 2010 on manufacturers and importers of brand-name prescription drugs. These fees are deposited in the Part B account.

Source: 2011 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Under an intermediate set of assumptions, trustees project that Medicare spending will grow rapidly, from about 3.5 percent of gross domestic product (GDP) today to 5.8 percent by 2040 and to about 6.3 percent by 2080.

- Compared with the projections before the Patient Protection and Affordable Care Act of 2010 (PPACA), Medicare's expenditures are projected to be a significantly smaller share of the economy—6.3 percent of GDP in 2080 compared with 11.2 percent under prior law. This projection is largely due to the provisions in PPACA that put in place permanent adjustments for productivity for most providers. The actuaries also project that PPACA will increase revenues to the Medicare program due to an expansion of the Hospital Insurance payroll tax and other revenue provisions.

Chart 1-13. Average monthly SMI premiums and cost sharing are projected to grow faster than the average monthly Social Security benefit



Note: SMI (Supplementary Medical Insurance). Average SMI benefit and average SMI premium plus cost-sharing values are for a beneficiary enrolled in Part B and (after 2006) Part D. Beneficiary spending on outpatient prescription drugs before 2006 is not included.

Source: 2011 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Between 1970 and 2009, the average monthly Social Security benefit (adjusted for inflation) increased by an annual average rate of 1.7 percent. Over the same period, average Supplementary Medical Insurance (SMI) premiums plus cost sharing grew by an annual average of 5.3 percent, and the value of the total SMI benefit grew by an annual average of 6.5 percent. Between 2003 and 2009, Part B premium increases offset 54 percent of the dollar increase in the average Social Security benefit.
- Growth over time in Medicare premiums and cost sharing will continue to outpace growth in Social Security income. Medicare trustees project that between 2009 and 2040 the average Social Security benefit will grow by 1 percent annually (after adjusting for inflation), compared with about 2.5 percent annual growth in average SMI premiums plus cost sharing. However, the growth rate of the value of the SMI benefit as well as SMI premiums and cost sharing is lower than projected before enactment of the Patient Protection and Affordable Care Act of 2010 (PPACA). SMI premiums and cost sharing are projected to grow in inflation-adjusted terms by 2.5 percent annually between 2009 and 2040 compared with 2.8 percent under prior law. This change is a result of the PPACA provisions affecting SMI—the permanent productivity adjustments for some Part B providers and the changes in payments to Medicare Advantage plans.
- Most Medicare beneficiaries pay their Part B premium by having it withheld from their monthly Social Security benefit. The December 2011 cost-of-living adjustment for Social Security benefits is projected to be 0.9 percent. Under current hold-harmless policies, Medicare Part B premiums cannot increase by a larger dollar amount than the cost-of-living increase in a beneficiary's Social Security benefit. Some beneficiaries may have their Part B premium increase limited as a result of the hold-harmless provision if their Social Security benefit is relatively small.
- Twenty-five percent of Medicare beneficiaries are not protected under the hold-harmless provision. They include: new beneficiaries in Medicare who did not pay a premium in 2010, high-income beneficiaries who pay the income-related Part B premium, and Medicare beneficiaries who are also eligible for Medicaid. (For the last group, Medicaid pays for their Part B premiums.)

Chart 1-14. Medicare HI and SMI program payments and cost sharing per beneficiary in 2009

	Average program payment (in dollars)	Average cost-sharing amount (in dollars)
HI	$4,861	$428
SMI	$4,644	$1,188

Note: HI (Hospital Insurance), SMI (Supplementary Medical Insurance). Average program payments and cost-sharing amounts are for fee-for-service Medicare only and do not include Part D. Medicare program payments represent unadjusted amounts paid for covered services incurred during a calendar year under Medicare fee-for-service only and exclude payments for managed care services. Program payments differ from benefit payments, which reflect estimates of interim and retroactive adjustments made to institutional providers as well as payments for managed care.

Source: Medicare and Medicaid Statistical Supplement 2010, CMS Office of Information Services.

- In calendar year 2009, the Medicare program made $4,861 in Hospital Insurance (HI) program payments and $4,644 in Supplementary Medical Insurance (SMI) program payments on average per beneficiary.
- In the same year, beneficiaries owed an average of $1,616 in Medicare cost sharing for HI and SMI.
- Most Medicare beneficiaries have supplemental coverage through former employers, medigap policies, Medicaid, or other sources that fill in much of Medicare's cost-sharing requirements.

Web links. National health care and Medicare spending

- The Trustees' Report provides information on the financial operations and actuarial status of the Medicare program.

  http://www.cms.gov/ReportsTrustFunds/

- The National Health Expenditure Accounts developed by the Office of the Actuary at CMS provide information about spending for health care in the United States.

  http://www.cms.gov/NationalHealthExpendData/

- The Medicare and Medicaid Statistical Supplement developed by CMS provides statistical information about Medicare, Medicaid, and other CMS programs.

  https://www.cms.gov/MedicareMedicaidStatSupp/

- CMS statistics provide information about Medicare beneficiaries, providers, utilization, and spending.

  http://www.cms.gov/DataCompendium/

- MedPAC's March 2011 Report to the Congress provides an overview of Medicare and U.S. health care spending in Chapter 1, Context for Medicare Payment Policy.

  http://medpac.gov/chapters/Mar11_Ch01.pdf